Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH OF FORT WORTH
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-12-1541-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since TDI moved to a 143% of DRG for inpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria. Medicare would have allowed this facility $9,171.19 for DRG 683 at 143%. Based on their payment of $9,058.93, a supplemental payment of $112.26 is due. There is a First Health PPO listed on the EOB. Our First Health contract is to pay 63% of TOTAL BILLED CHARGES = $11,551.71 for this claim--obviously they didn't use this contract to price the claim. We request additional payment of $112.26."

Amount in Dispute: $112.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the request for additional information, our 3rd party repricer was asked to retrieve the requested information, if possible. It was determined that the provider did not have a contract and there were no PPO reductions taken per the original EORs."

Response Submitted by: ESIS, P. O. Box 6563, Scranton, PA 18505-6563

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2011 To August 3, 2011	Inpatient Hospital Surgical Services	$112.26	$112.26

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.

3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 1, 2011
   - 1 – (W1) – Workers Compensation State Fee Schedule Adjustment.
   - 1 – The charge for this procedure exceeds the fee schedule allowance. (Z710)

   Explanation of benefits dated November 30, 2011
   - 1 – (W1) – Workers Compensation State Fee Schedule Adjustment.
   - 1 – This bill was reviewed for ESIS treatment parameters. (MT39)
   - We are unable to recommend an additional allowance since this claim was paid in accordance with the state's fee schedule guidelines, First Health Bill Review's usual and customary policies, and/or was reviewed in accordance with the provider's contract with First Health. (Z951)

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. According to the explanation of benefits, the services in dispute were reduced pursuant to an informal network contract as described by Texas Labor Code §413.0115. Texas Labor Code Section §413.011(d-3) states that the division may request copies of each contract under which fees are being paid and goes on the state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division. On March 7, 2011, the division requested a copy of the contract between the network and the health care provider, and documentation to support that the requestor was notified in accordance with 28 Texas Administrative Code §133.4. The carrier responded to the Division's request to provide a copy of the contract stating, "Upon receipt of the request for additional information, our 3rd party repricer was asked to retrieve the requested information, if possible. It was determined that the provider did not have a contract and there were no PPO reductions taken per the original EORs." Consequently, the carrier is required to pay fees in accordance with 28 Texas Administrative Code §134.404 for the services in this dispute.

2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).

   Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 683 is $6,472.74 This amount multiplied by 143% is $9,256.02. The total maximum allowable reimbursement (MAR) is therefore $9,256.02. The respondent previously paid $9,058.93. The requestor's *Table of Disputed Services* lists the total amount in dispute as $112.26, therefore this amount is recommended for payment.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $112.26.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $112.26 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 20, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.